ATTACHMENT A

OVERVIEW OF MAA AND BASIC HEALTH PROGRAMS

I. MEDICAID MANDATORY PROGRAMS

Section 1902(a)(10)(A)(i) of Title XIX requires states to provide a minimum amount of health care coverage for certain individuals identified as categorically needy (CN). Washington State covers these individuals under the following eligibility groups.

CN Family Medical

CN Medicaid coverage is provided to TANF (Temporary Assistance for Needy Families) households – dependent children under age 19 and the adults who care for them. In Washington State, the household must have income below the TANF income standard (45 percent of the federal poverty level (FPL)) and have resources not greater than $1,000, excluding their home and vehicle. Once a family is eligible for assistance, there are no resource limits. In determining income eligibility for TANF and Medicaid coverage, a family can deduct 50 percent of their earnings, actual childcare costs and child support paid out by the family. These eligibility income adjustments effectively allow families up to about 100 percent of poverty to receive medical coverage. Families also may elect to receive only medical coverage and not use their 60 months of lifetime TANF assistance coverage.

Once households' cash benefits are terminated because of earned income, the TANF families are eligible for 12 months of Transitional Medical Assistance. Beginning in July 2002, families will be required to pay a monthly premium of approximately $15 per adult per month during the second six-months of their transitional coverage.

Washington's CN Family Medical program currently (July 2001) covers some 272,100 persons per month (35 percent of all Medicaid clients). About 177,600 (65 percent) of these family members are children. Approximately 48 percent of the families are receiving medical and grant assistance, 29 percent are receiving medical only, and 23 percent are working with incomes above grant coverage and are receiving Transitional Medical Assistance coverage.

CN Aged

CN Medicaid coverage is provided to persons age 65 and older with income and resources below the federal Supplemental Security Income (SSI) limits. In Washington, the SSI grant plus state Supplement Payment is $556 (78 percent of poverty) for a single person and $816 (84 percent of FPL) for a couple. SSI coverage also imposes resource limits - $2,000 for a single person and $3,000 for a couple. However, certain resources, such as home, personal effects, vehicles, are exempt.

About 43,500 (6 percent of all Medicaid clients) elderly persons are currently receiving mandatory coverage. Nearly 85 percent of these persons are also covered by Medicare. Medicaid provides all State Plan services not covered by Medicare, such as prescription drugs, and also pays the persons' Medicare cost-sharing obligations.

CN Blind/Disabled

CN Medicaid coverage is provided to blind and disabled persons who meet SSI disability standards. Disability is defined as the inability to engage in any "substantial gainful activity" (SGA) by reason of a medically determinable physical or mental impairment that is expected to last for a continuous period of not less than 12 months, or to result in death. SGA is defined in Federal regulations as earnings of $700 per month. Persons with Social Security Disability Insurance (SSDI) whose disability payments are below the SSI standard can also receive SSI supplemental payments up to the grant amount. These dual SSDI/SSI persons also are eligible for CN Medicaid coverage to supplement their Medicare coverage.

The SSI program has work incentive provisions that allow working disabled persons to continue to receive grant and medical coverage. Under 1619(a) provisions, working disabled persons in Washington can earn up to about 170 percent of FPL and retain their medical coverage and a portion of their grant. Under 1619(b) provisions, working disabled persons can earn up to about 218 percent of FPL and retain their CN medical coverage.

About 103,000 (13 percent of all Medicaid clients) blind and disabled persons in Washington State are currently receiving mandatory coverage. Approximately 28 percent of these persons are also covered by Medicare and receive wrap-around coverage and Medicare cost-sharing coverage.

CN Pregnant Women and Infants

States' CN Medicaid programs are required to offer coverage to pregnant women and infants with incomes up to 133 percent of FPL. At their option, states have been able to offer coverage up to 185 percent of FPL. Under federal law, once coverage is offered at the higher income level, it becomes a mandatory coverage requirement. Washington began offering coverage up to 185 percent of FPL in 1989, as part of its First Steps initiative to improve children's health.

There are no resource requirements for coverage. In determining eligibility income, a family can deduct $90 per month of earned income for each working parent, actual childcare costs, and child support paid out by the family.

Postpartum coverage is also provided for women who deliver. This coverage extends for 60 days after the month in which the pregnancy ends. During this period, the women and infants are eligible for full-scope coverage. Thereafter, state-funded family planning coverage has been offered for an additional ten months to all women. Under a recently enacted 1115 demonstration waiver, free family planning coverage is available to all women and men with incomes at or below 200 percent of FPL.

About 15,900 (3 percent of all Medicaid clients) women are currently receiving mandatory coverage. In addition, Washington provides state-funded coverage to about 6,200 pregnant women who do not meet federal citizenship requirements.

CN Mandatory Children's Medical

States are required to offer coverage to certain low-income children, and may at their option cover higher income children. Washington's mandatory eligibility group coverage includes: infants up to age 1 in households up to 185 percent of FPL; children age 1 through 5 up to 133 percent of FPL; and children age 6 through 18 up to 100 percent of FPL. Federal law allowed states a phase-in period through September 2003 to cover children through age 18 up to 100 percent of FPL. Washington adopted this mandatory coverage level in 1992, as part of its on-going initiative to improve children's health. In addition to these children, CN mandatory coverage is provided to all children in state foster care placement.

There are no resource requirements for coverage. In determining eligibility income, a family can deduct $90 per month of earned income for each working parent, actual childcare costs, and child support paid out by the family.

Washington's Medicaid program currently covers 503,900 children. Approximately 178,000 (35 percent) receive their coverage through the Children's Mandatory eligibility

groups. The remainder receive coverage through the Family Medical program, CN Blind/Disabled, or through Medicaid CN Optional coverage.

Medicare Cost-Sharing Coverage

States are required to pay for low-income Medicare beneficiaries' cost-sharing requirements. For beneficiaries, not otherwise eligible for Medicaid CN or Medically Needy (MN) coverage, Washington pays for Medicare deductibles, copayments, Part B premiums, and Medicare Part C for managed care related costs. This coverage is offered to persons with incomes up to 100 percent of FPL through the Qualified Medicare Beneficiary (QMB) program. As described above, Medicare clients covered under the CN Aged, Blind, and Disabled eligibility groups also have their Medicare cost-sharing covered. There are currently about 11,300 QMB-only persons receiving coverage in Washington State.

Washington also covers Medicare Part B premium costs for persons with incomes between 100 percent and 120 percent of FPL through Specified Low-Income Medicare Beneficiary (SLMB) coverage. To be eligible the person must also be eligible for Medicare Part A hospital coverage. Medicaid also will pay the Part B premium costs for Medicare beneficiaries with incomes between 120 percent and 135 percent of FPL through Expanded Specified Low-Income Medicare Beneficiary (ESLMB) coverage. In addition Medicare beneficiaries with income up to 175 percent of FPL can receive limited cash assistance towards their cost-sharing through the Qualified Individual (QI-2) program. Medicaid also will pay Medicare Part A premiums for working disabled persons with incomes up to 200 percent of FPL through Qualified Disabled Working Individual (QDWI) coverage.

Refugee Assistance

Persons who have been granted asylum in the United States may receive cash benefits and CN Medicaid coverage for up to eight months. This coverage is entirely federally funded. Refugees/asylees who have been in the United States for more than eight months are determined eligible for medical benefits the same as United States' citizens. In Washington, about 1,200 refugees/asylees per month receive Medicaid coverage.

II. MEDICAID OPTIONAL PROGRAMS

In addition to mandatory groups, states may offer optional Medicaid coverage through the Categorically Needy (CN) and Medically Needy (MN) programs. As part of its ongoing efforts to offer affordable health care coverage to low-income persons,

Washington State has elected to use its Medicaid program to offer optional coverage to a number of groups.

CN Optional Aged

States at their option can offer Medicaid coverage to elderly persons with incomes at or below the SSI grant standard who do not receive SSI grants. They also can offer coverage to elderly persons with incomes up to 300 percent of the SSI grant standard (currently $1,590 per month for a single person) who need institutional level of care in a medical facility. In Washington, these persons would be eligible for either skilled nursing facilities or home and community-based services offered through the COPES waiver program. There are an estimated 8,100 higher income elderly persons eligible under this institutional status.

CN Optional Blind/Disabled

As with the elderly, states also can offer Medicaid coverage to blind or disabled persons with incomes at or below the SSI grant standard who do not receive SSI grants. They also can offer coverage to blind or disabled persons with incomes up to 300 percent of the SSI grant standard who need institutional level of care in a medical facility. In Washington, these persons would be eligible for either ICF-MR or home and community-based services offered through the CAPS waiver program. There are an estimated 1,500 higher income disabled persons eligible under this institutional status.

CN Optional Children's Coverage

In addition to the mandatory coverage described above, Washington State offers CN medical coverage to children under age 19 in households up to 200 percent of FPL. There are no resource requirements for coverage. In determining eligibility income, a family can deduct $90 per month of earned income for each working parent, actual childcare costs, and child support paid out by the family. Coverage and all other aspects of this optional coverage are the same as the mandatory program for children.

Washington has offered this coverage since 1994. In 1996, the year preceding the enactment of the State Children's Health Insurance Program (SCHIP), Washington was one of only four states in the country offering Medicaid coverage to children at or above 200 percent of FPL.

There are currently some 132,600 children receiving coverage through this optional program. This is about 26 percent of the 503,900 children covered under the Medicaid program.

CN Optional Breast & Cervical Cancer

The Breast and Cervical Cancer Prevention Act of 2000 allows states to offer Medicaid CN optional coverage to certain low-income women diagnosed with breast or cervical cancer. To eligible, the women: must have been screened for breast or cervical cancer under the Centers for Disease Control (CDC) Title XV funded Breast and Cervical Cancer Early Detection Program; found in need of treatment; be uninsured; and be under age 65. If eligible, the women can receive full-scope CN coverage until their course of treatment is completed. States receive enhanced SCHIP match for this program.

Washington State is one of 19 states that offer this coverage. Washington's coverage began July 2001. In Washington, most Title XV diagnosis programs are funded through the State's Department of Health Breast and Cervical Health Program. Eligibility is offered to women with incomes up to 200 percent of FPL, ages 40 through 64, and who are uninsured. Over the past five years, about 65 women per year have been diagnosed by the program as having breast or cervical cancer. It is estimated that about 80 women per month will receive coverage by the end of next year.

CN Optional Medicaid Buy-In Program

The Ticket to Work and Work Incentives Improvement Act of 1999 allows states to further expand Medicaid coverage for the working disabled. States can offer CN optional buy-in coverage to individuals age 16 through 64 with a SSI determined disability. The Buy-In program gives states broad flexibility to establish their own income and resource eligibility limits, and broad flexibility to adopt cost-sharing. Federal law allows states to impose copayments and premiums so long as they do not exceed 7.5 percent of income for persons up to 450 percent of FPL.

The 2001 Washington State Legislature enacted legislation and funding for the Department of Social and Health Services to implement a Medicaid Buy-In program. Coverage will be offered to working disabled persons with gross incomes up to 450 percent of FPL. Persons will be required to pay a premium based on 5.0 percent of their unearned income plus 5.0 percent of the adjusted earned income using SSI income exemptions. The person also will be required to pay a "monthly enrollment" fee.

The Medicaid Buy-In program is scheduled to be implemented in January 2002. It is estimated that by June 2003, there will be approximately 1,100 working disabled persons receiving coverage through the program.

Medically Needy Program

Washington is one of 23 states offering optional coverage through the Medically Needy (MN) program. The program is offered to elderly persons who otherwise qualify for CN coverage except that their income or resources exceed CN eligibility requirements. In order to qualify for coverage, a person's countable income (gross income minus those adjustments allowed for SSI) must be less than the state's Medically Needy Income Level (MNIL). In Washington, the MNIL is $556 (78 percent of FPL) for a single person and $592 (61 percent of FPL) for a couple. Resource limits for countable resources are $2,000 for a single person and $3,000 for a couple.

If individuals have income greater than the MNIL, they may obtain coverage if they have incurred medical expenses. If their spend-down (income minus medical expenses) amount is less than the MNIL standard, they are able to obtain temporary coverage. The client may choose between a three-month or six-month base period to compute their monthly incurred medical expense. The base period also establishes their eligibility period. Medicaid coverage under the MN program is slightly less than CN Medicaid coverage.

Washington covers three eligibility groups in its MN program. Federal law requires that all state MN programs offer coverage to pregnant women and children. Given Washington's high CN coverage levels for these groups, there are less than 100 persons per month in this group.

Washington also covers aged and blind/disabled eligibility groups. There are some 5,500 elderly persons per month who are covered under the MN Aged group. Nearly all these individuals are also covered under Medicare. The MN program allows these persons to receive coverage for State Plan services not covered by Medicare, such as prescription drugs and medical equipment.

There are about 7,700 disabled persons per month covered under MN Blind/Disabled. About 76 percent of these persons also are covered by Medicare, and often have SSDI assistance.

III. CHILDREN'S PROGRAMS

Washington's Medical Assistance programs provide heath coverage to some 529,600 children. This is 33 percent of all children in the state. Most (95 percent) of the coverage is through the Medicaid programs described above. However, the state also provides coverage through its State Children's Health Insurance Program (SCHIP) and Children's Health Program (CHP).

SCHIP

In Washington State, SCHIP offers coverage to children in households between 200 percent and 250 percent of FPL. The program is a non-entitlement Medicaid "look-alike" program. SCHIP has the same full-scope benefit design as the Medicaid CN children's program. Unlike the Medicaid program, SCHIP has $5 copayments for office visits (no copayments for preventive services), $5 copayments for brand name prescription drugs and $25 copayments for emergency room visits (waived if admitted for inpatient care). Families also are required to pay monthly premiums ($10 per child, $30 family maximum) with an annual out of pocket maximum based on family size.

Washington implemented the SCHIP program in February 2000. It is currently covering 4,500 children. Enrollment rates are being reforecast, but it is worth noting the 2000 Washington State Population Survey estimated that there were only about 7,000 children between 200 percent and 250 percent of FPL who were uninsured in March/April of 2000.

CHP

In 1991, Washington expanded coverage to all children up to age 18 in households up to 100 percent of FPL. This coverage was offered through the state-funded Children's Health Program. This expansion was an extension of the First Steps program implemented in 1989, which covered pregnant women and infants up to 185 percent of FPL. In 1992, the program was converted to Medicaid under Section 1902(r)(2) provisions.

Children who did not qualify for Medicaid coverage due to citizenship requirements continued to receive coverage through CHP. The program has the same coverage and eligibility criteria as the Medicaid program, except that neither the maximum age nor household income level increased when Medicaid expanded to 200 percent of FPL. CHP remains at 100 percent of FPL for children under age 18. The program continues to offer coverage to a growing number of low-income children. Currently, there are some 19,500 children receiving full-scope coverage through this program.

IV. OTHER STATE MEDICAL ASSISTANCE PROGRAMS

Medical Care Services

Washington State offers General Assistance (GA) financial grants to persons who are unemployed due to a physical or mental health incapacity. The incapacity level is lower

than the SSI disability level. In general, persons are considered incapacitated if they are incapable of gainful employment as a result of a physical or mental impairment that is expected to continue for 90-days or more. Grant assistance is $339 (47 percent of FPL) per month for a single person. GA has work incentives similar to SSI, which allows an individual to earn up to the poverty level before losing assistance.

While receiving GA grant assistance, persons also are eligible for medical coverage through the Medical Care Services (MCS) program. MCS coverage is less comprehensive than CN Medicaid coverage, and does not cover long-term care, mental health, and has restricted dental coverage. Unlike the TANF program, there is no transitional medical coverage for persons leaving assistance. There currently are some 10,400 GA clients receiving MCS coverage.

MCS coverage is also offered to persons receiving grant assistance under the Alcoholism and Drug Addiction Treatment & Support Act (ADATSA) program. This time-limited program offers alcohol and drug treatment for persons incapacitated from gainful employment due to alcoholism or drug addiction. There are 3,300 ADATSA persons per month receiving MCS coverage.

Medically Indigent Program

Low-income persons with an emergent medical condition requiring emergency room or inpatient hospital services and who are not eligible for any other federal or state program may obtain coverage for their emergent care through the Medically Indigent (MI) program. In order to qualify for coverage, a person's countable income (gross income minus those adjustments allowed for SSI) must be less than the state's MI Income Level, which is the same as the Medical Needy Income Level of $556 (78 percent of FPL) per month. Resource limits for countable resources are $2,000 for an individual. Excess resources and excess income may be spent down to the resource level.

In addition a MI client is subject to $2,000 Emergency Medical Expense Requirement (similar to a deductible) for a 12-month period. Coverage is limited to three months in any 12-month period. Benefit coverage is limited to emergency transportation, emergency room services, inpatient or outpatient hospital care, and physician services provided in the hospital. On average, there are about 2,000 persons per month receiving MI coverage.

V. Basic Health Program

In addition to children's coverage, Washington also has been a national leader in offering innovative health care coverage to families and individuals through the Basic Health (BH) program. Based on a 1986 study by the Washington Health Care Project Commission, the 1987 Washington State Legislature enacted legislation and funding for BH and the Washington State Health Insurance Pool (WSHIP). BH was implemented in 1988 as a managed care demonstration project. The legislature originally gave funding authority to cover up to 22,000 residents with incomes up to 200 percent of FPL.

As part of its 1993 comprehensive health reform legislation, the legislature expanded BH into a permanent program, lifted the enrollment cap, and merged it with the state's Health Care Authority (HCA), which is responsible for purchasing health care insurance for state employees and other local governmental employees. The legislature also created the Health Services Account (HSA) to fund BH, public health and other health initiatives.

In 1995, the legislature specifically authorized coverage to be expanded, beginning in 1996, to include mental health, chemical dependency and organ transplants. Funding also was provided to restructure the BH premium schedule to be more affordable. Currently, BH is providing coverage to 129,000 persons per month.

Due to growth in health care expenditures and concern over HSA revenue, the 2001 legislature appropriated funding to cover approximately 125,000 persons. BH will be managing enrollment to achieve this level by January 2002.

BH offers a benefit plan that includes: hospital care; emergency care; medical and surgical care; organ transplants; preventive care; maternity care (through Medicaid for those who are eligible); plastic and reconstructive services; pharmacy benefits; mental health services; chemical dependency services; short-term skilled nursing and home care benefits as an alternative to hospitalization in an acute care facility; and hospice services. BH coverage does not cover the entire scope of medical benefits offered under Medicaid, including: vision care; speech, occupational and physical therapy; and dental coverage.

BH has copayment requirements except for preventive care, lab and x-ray, and emergency use of outpatient facilities if the patient is admitted. Enrollees are required to pay monthly premiums based on an eight-tier schedule, based on household income, age, family size and choice of health plan.

HCA and DSHS have undertaken a number of initiatives to create seamless coverage for families eligible for BH and Medicaid coverage. In 1994, the agencies implemented

Basic Health Plus (BH+), whereby Medicaid eligible children with BH parents could be in the same managed care plan as their parents and receive free, full-scope Medicaid coverage. HCA contracts for both BH and BH+ coverage and receives Medicaid payments from DSHS for the children's coverage. The two agencies coordinate so that families only have to apply through HCA to obtain BH and BH+ coverage. Currently there are 56,000 Medicaid children in BH+. In addition, eligible pregnant women receive free, full-scope Medicaid medical and prenatal care coverage through their BH plan for up to 60 days post partum.